Community Service Network 7 Meeting
DHHS Offices, Biddeford
November 13, 2008

DRAFT Minutes

Members Present:

• Don Burns, AIN • Lois Jones, Counseling Services, Inc. • Jennifer Goodwin, Counseling Services, inc.	• Deborah Rousseau, MMC Vocational Employment Coordinator • Barb Murray, MMC Emp Spec, CSN 7 • Chris Souther, Shalom House	• Jean Ellis, SMMC • Mary Jane Krebs, Spring Harbor • Jen Ouellette, York County Shelter Programs

Members Absent:

• Center for Life Enrichment (vacant) • Common Connection club & CCSM (CSI) • Creative Work Systems	• Goodall Hospital (excused) • Harmony Center & CCSM (CSI-excused) • NAMI-ME Families	• Riverview Psychiatric Center • Saco River Health Services • York Hospital

Others/Alternates Present:

• Jennifer Anderson, Schaller Anderson • Tammy Smith, Schaller Anderson Eric Meyer, APS	• Eric Meyer, APS Healthcare • Pam Holland, Maine CDC	• Kelly Shaughnessy, Volunteers of America

Staff Present: DHHS/OAMHS: Carlton Lewis and Lisa Wallace. Muskie School: Scott Bernier

Agenda Item	Discussion
I. Welcome and Introductions	Carlton opened the meeting with introductions around the table.
II. Review and Approval of Minutes	Both September and October minutes were approved.
III. Feedback on OAMHS Communication	Comment: So much data is produced that we don't have time to review all the data.
IV. APS Healthcare	Lisa Wallace introduced Eric Meyer and provided some of Don Chamberlain's findings to the group: **<u>Summary Findings from Visits to Selected Mental Health Providers by Don Chamberlain, DHHS/OAMHS</u>** At the suggestion of Don Harden of Catholic Charities and the Chair of the Adult Committee of MAMHS, Don Chamberlain and a mental health team leader conducted site visits to get an on-the-ground view of the APS Healthcare process. Mr. Chamberlain asked Mr. Harden to set up site visits with a number of providers ranging from a low tech provider to a high tech provider. He also asked the Behavioral Health Collaborative for a couple of providers to meet with. Mr. Chamberlain and the mental health team leader from the appropriate region met with front line staff, supervisors, billing staff, and others from the organizations. The agencies are: Shalom, Catholic Charities, Common Ties, Kennebec Behavioral Health, CSI, and Community Counseling Center. **<u>The findings</u>**: • For continuing stay reviews, the additional time required is from 20 minutes to one hour per case. The low end is for therapists in outpatient settings. Other than one provider, all the rest have to take their treatment plan in their clinical record and translate it to Care Connections. This task seems to be easier for master's level clinicians than MHRTCs.

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	• Most providers have established systems that require the plan to be reviewed by either the supervisor or the Quality Department prior to submission. This adds time internally before the data can be entered into APS. • The increase of CI from six-month continuing stay reviews to every 90 days has substantially increased the administrative costs to CI providers. To do the RDS would take a much more limited time. **Recommendation: Get the RDS information at the 90-day mark and do the full continuing stay at the six-month point.** • The comment section of CareConnections is being used for additional goals and other ongoing information which can not be brought forward in continuing stay reviews, which results in additional work for each review. • A decrease in initial authorization visits for outpatient services results in more reviews than need to occur. The original authorization allowed the treatment of many consumers to be completed and therefore not require a review. The current initial authorized visits cause nearly every case to require a continuing stay review. **Recommendation: Return to the earlier number of authorized visits.** • One provider has an electronic interface which eliminates, for the most part, the need for clinicians or others to enter the information. However, every time there is an APS change, the provider must pay an IT cost. • While there was a reduction in the information required for outpatient for continuing stay reviews, one has to go through all the pages to get to the appropriate section, which causes confusion and time. • When a question arises, telephone tag on both sides requires more time. • Given the agency processes and the telephone tag, the five-day pre- and post-the date for review is difficult to meet. **Recommendation: Increase from 5 to 7 days on either side.** • For PNMI, the 30-day review is a bit short since the OAMHS has approved the placement in the first place. Getting the registration and discharge into APS in the 24-hour time frame is sometimes problematic. **Recommendation: Increase the time frame for the continuing care review and allow an additional 24 hours to get registration and discharge data into APS.** • **Recommendation: Those with computerized records would like batch up loading to save time and expense on the provider side.** • General concerns regarding the language and information that APS is asking is medically oriented based upon problems whereas the ISP is strength-based. Licensing may require something else. **Recommendation: That these be aligned.** • There is variability in agency capacity to easily track visits and time for approvals from one agency that has had to set up a spread sheet to an agency in which all is computerized and can send out reminders. • Everyone indicated that the reviewers and staff at APS were easy to work with and very professional. ((The findings listed above reflect a report issued by Mr. Chamberlain following this meeting and are not an exact transcription of discussion at the meeting). **Questions/comments**: • When you're talking about information forward, what is that? A: In the initial application for prior authorization, you have to enter all the data. At the next request, you can copy that information forward to the new request without having to recopy all the data. This isn't working for info entered in the text boxes. • Were the text boxes a state requirement? A: No. When the system was first designed, it was not expected that text information would need to be moved forward. APS is working to fix this. • What are batch uploads? A: Agency's computer systems can send all records to APS at once. This is called a batch upload. • So there are no HIPPA issues with the system? A: Correct. • The purpose of the meetings Don held was to get feedback? A: (Response from Eric) We've appreciated the feedback to fix the system. We know there are a lot of providers who didn't participate. As such, APS is going

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	around to all seven CSNs to get more feedback. The forum we are providing will allow you to report how you use APS, who is doing what with the system, the time involved, etc. It will also allow you to identify possible changes/solutions that would make the review process more sustainable. There are several areas that could be addressed to help you such as requirements in conjunction with DHHS and sometimes, what you report might be corrected by us offering you training. This will not be a one-time shot at data gathering. We will provide a response to this initial round of feedback in January. • It sounds like you have staff for training. A. Yes. • Once you approve services, what is the time frame for an agency to get compensation? A. Claims payment piece with MaineCare is the same. The challenge providers are facing is billing using the authorization number. • CSI reports they are waiting a considerable amount of time and the margin of error is larger now. We appreciate being able to give feedback. • Lisa reported that DHHS has chosen to contract with UNISYS to take care of MaineCare claims payments beginning in 2010. Data collected by APS was passed around and reviewed. There are 60 reports that APS generates under Appendix C of its contract with DHHS. It is expected that as we all move forward, if you see something that doesn't look right, please give them (APS) feedback. Reports will be posted on the APS website. There are not a lot of outcomes yet. That will be in the next phase of reporting in 2009. APS hopes to do quarterly conference calls on these reports. Questions/Comments: • Related to the data: We're reporting a lot of stuff. I'm hoping that reporting/data collection will be streamlined. A: We are aiming for that. DHHS doesn't necessarily want all this data. • Feedback: It would be nice to get a copy of the data we are providing.
V. Disaster Behavioral Health Team	Pam Holland, Director of Disaster Behavioral Health in Maine, introduced herself and gave a PowerPoint presentation in regards to the Maine Disaster Behavioral Health Response Teams. Highlights of the presentation: • The congressional Disaster Relief Act of 1974 required parity of mental health with physical/medical risks associated with post disaster symptoms. • Maine has experienced four natural disasters since 1998 (Ice Storm, Flooding, and Patriot's Day Storm) • Maine established a Disaster Behavioral Health position at the Maine Center for Disease Control and Prevention. • A resource manual was produced for each county. • A curriculum was developed to train volunteers in each county in disaster behavioral health (DBH) • Eight 2-day trainings have been conducted so far. Two more are planned this month. • To date, 175 volunteers have been trained in this curriculum • There is now a seat in the state and in each of the county's Emergency Response Centers (EOC) for DBH personal. Pam sits in the state seat to coordinate responses to psychological first aid (PFA) at the county level. • PFA has five basic steps: o Make contact with the individual o Stabilize their situation (safety/comfort) o Gather information on their needs and concerns o Develop a plan (practical assistance) o Follow-up on the plan

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	• DBH is mobilized by through activation by the Maine Emergency Management Agency (Maine EMA) and/or by request of County EMA
	• Goals of DBH include:
	  o Have trained volunteers in all counties
	  o Capacity for local response in all counties for local people prefer to deal with local people
	  o Active volunteers to respond promptly as early intervention is the key to quicker recovery
	  o Collaboration with regional resource centers and crisis agencies
	  o Utilize resources already in place
	  o Offer drills & exercises to be better prepared for responding to disasters
	• In the future:
	  o a Northeast consortium of states is forming around DBH.
	  o There will be a formal memorandum of understanding (MOU) with the American Red Cross
	  o An MOU with crisis agencies to collaborate trainings in PFA
	  o Train volunteers in 4 more counties
	  o Provide another round of training in the 3 counties that were in the pilot training
	  o Offer IS-100 & IS-700 for Incident Command System training in state in December. Training is normally online. The half day Dec. training will prepare attendees for the online examine.
	
	Questions/comments/feedback:
	• This is a really good training.
	• Would you prefer that those who are trained are not already first responders, correct? A: We would not discourage them, but we need people we can call upon in a disaster.

VI. Schaller Anderson	Jennifer Anderson of Schaller Anderson was introduced to the members present. She gave a little of her background and the history of the company she works for: • Schaller was founded 20 years ago in Phoenix, AZ and managed Arizona's Medicaid program—providing care management to beneficiaries. • The company has grown over the years and now performs similar services in several states. • The company has a contract with MaineCare to provide similar services here. • Schaller uses a predictive modeling system to examine MaineCare claims data and identify the top 10 percent of adults and the top 5 percent of children who are chronically ill and have high usage of health care services. Schaller provides care management to improve clients' health status. Most of the people working for the company in Maine are from Maine. Schaller has two offices – in Portland and Bangor – that cover the entire state. • Under care management, Schaller provides the following: if someone called looking for heating assistance, they would give that person contact info to obtain that assistance in their area. Or if someone who has diabetes and is diagnosed as schizophrenic, that person's case manager may only know how to help that client with the mental health side, but not the health care side. Schaller Anderson would help them obtain services for the diabetes. • Overall, their goal is to improve care for clients and save the state money. • When they started, they were provided only the healthcare data and not the behavioral health data. That has been corrected and is one of the reasons they are going around to all the CSNs to introduce themselves. Questions/comments/feedback: • Are you strategies case management or preventative? A: We don't want to duplicate services. Behavioral health

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	providers have told us they have the mental health end, you have the nurses, so can you talk to health providers to help us. We're here to help you and your clients. • You don't bill for the services you provide? A: We don't "count" because we do not bill. • Is one of your focuses self-management? A: Yes, to the best of the member's ability. • I have concerns about this. We have patients who are receiving both services already. This seems to be a duplication of services. A: Sometimes, we find that services are all covered. We're also available to help find transportation and paying utilities. • I've watched providers lament over the loss of money for services. It appears you are offering to coordinate an individual's needs. You are the fill-in-the-gaps agency. • How are you getting names now? A: We started on the medical side. We discovered a part of that population have serious mental health issues. We've found who is providing services now and that is why we're here at this meeting. How can we help you? • Are you contacting providers? A: Yes, that is what we want to be able to do. • What about confidentiality? A: We are a business agent for DHHS. • I was horrified at the reduced life expectancy of mental health consumers, as much as 25 years less. I think you will be useful. • Carlton noted that research has found that those who are mentally ill are not getting the same health treatment as others. • Is there a reporting component showing you have saved money and what are the implications for assessment by other providers? A: We submit reports weekly to the state. In just a year, we have reduced emergency room and inpatient visits. • What will your data say about my program? A: I'm not sure it will say anything. • It would be great to have a primary care physician within the psychiatric setting rather than the other way around. • Are you getting the same questions from the other CSNs? A: Yes, they have all been similar to yours. We have two more CSNs to visit. • So the claims you are reviewing are from MaineCare? A: Yes. • What about others? A: We are only doing MaineCare as our contract is to help reduce MaineCare costs and save the state money. • Community integration has been so streamlined that it doesn't cover these services anymore. You've found a niche. • It sounds like you're providing services/making interventions. A: We are providing reviews and managed care. • Who pays you? A: The state via contract. • So the state doesn't have UR nurses for non-behavioral health uses? A: Not that we know of.
VII. Consumer Council Update	There was no one present to provide a report.
VIII. WRAP Funds Proposal	York County Shelters and CSI met and worked together to produce a proposal on how WRAP funds will be administered and distributed in CSN 7. The proposal was handed out for review. The recommendation is that CSI will receive and manage the funds. CSI, York County Community Action Program, and York County Shelters will work together via email to determine who receives funds. Question/comments: • Directed at Carlton: Is course/education allowable, for example an adult ed course? A: WRAP funds are for basic urgent need only. Education is not considered an urgent need, so no.

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	• Do people need to be registered in APS to have access to the funds? A: No, class members may not be enrolled in services. If the person meets Section 17 criteria, they qualify for WRAP funds. • Don said that there was a six-month allotment. Would this procedure be part of the contract for the next 6 months? A: No. • On the section on heat assistance: Is that worded correctly? A: Yes, this is intended as a stop gap measure only. • If we wanted to change the procedure down the road, does it need to be reviewed? A: You can discuss changes at these CSN meetings. • Please note that CSI has clients in Westbrook, but there isn't separate money for them in Cumberland County yet.
IX. Budget	We do not have any details yet. There will be curtailments and cuts for the next two years. To quote Ron Welch: We should be thinking about major system changes. Q: At what point will we know what the recommendations are: A: We haven't seen them yet. Nothing is resolved yet.
X. Report from Employment Specialist and Employment Service Network	Tony is no longer the ESN rep for this CSN. It is now Barb Murray. Barb was welcomed by the group. Reports will be provided at future meetings.
XI. Other	See Appended data next page in regards to CSI Crisis Data per the ACTION item in the Oct. minutes.
XII. Public Comment	None.
XIII. Meeting Recap and Agenda for Next Meeting	See **ACTION** items above. Legislative & Budget Update Consumer Council System Update Employment Specialist Update Impact of Energy Costs Wraparound Funds Proposal

CSI Crisis Data

Count of LastName	June 08 Summary of Locations seen all cases
Loc Type	Grand Total
CRS Total	47
ER Total	195
Home Total	17
Mobile Total	10
School Total	1
#N/A Total	7
Grand Total	277

Cases	Number
Total Cases Seen in ED's	195
Brought in by PD	57
Brought in by Rescue (not OD)	23
Brought in by Family	19
Drected in by CRS	16
Walked in self	15
Brought in by Rescue OD	11
Brought in by Friend	11
Miscellaneous	43

Location	Hospitalization Rates
Goodall	23%
SMMC	34%
York	26%
Overall	31%